Overview

The Office of the Health Insurance Commissioner (OHIC) of the State of Rhode Island has a comprehensive and innovative rate review process established for all lines of commercial insurance. OHIC proposes to use federal funds available to states through the US Department of Health Human Services' (HHS) Premium Review Grant program to accomplish three goals: (1) expand the scope of current rate review and approval activities; (2) enhance the rate review process through staffing; and (3) improve consumer protection standards and communications in the rate review process. These goals align with HHS' objectives for Cycle I funding:

> (1) *Thorough evaluation of proposed health insurance rate increases and, to the extent permitted by law, (dis)approval through a comprehensive rate review process that is meaningful and transparent to all stakeholders; and*
> (2) *Infrastructure development to collect, analyze, and report to the Secretary critical information about rate filings and the review and, to the extent permitted by law, the approval and disapproval process.*

OHIC will meet HHS grant objectives, improve the effectiveness of health insurance rate regulation in Rhode Island, and provide valuable lessons for other states engaged in this process.

A. Current Health Insurance Rate Review Capacity and Process

Health Insurance Markets and Regulatory Structure in Rhode Island

In the commercial health insurance market for those under 65 years of age, there are three major medical insurers in Rhode Island: Blue Cross Blue Shield of Rhode Island (BCBSRI), United Healthcare of New England, and Tufts Health Plan. Within the state, these three insurers comprise 81%, 15%, and 4% of fully-insured market share respectively. All three sell products in the small and large group markets. Approximately 88,000 lives are covered in the small group market and 248,000 lives in the large group market. BCBSRI is the only carrier that sells individual market products in the state, covering approximately 15,000 lives. An additional 223,000 lives are covered in the commercial market through self-funded groups; however, these

groups are exempt from state-based regulation and consequently premium review. OHIC regulates all commercial health insurance products sold within the individual, small, and large group markets. In addition, approximately 32,000 residents buy Medicare supplemental ("Medigap") insurance regulated by OHIC. Certain other accident and sickness (limited benefit, limited duration, disease specific coverage) policies sold in Rhode Island are regulated under a separate set of statutes by OHIC's sister agency, the Department of Business Regulation (DBR).

Prior to 2004, DBR was authorized by statute to review proposed health insurance premium rate factors annually for small and large employers.[1] DBR, in standard practice, reviewed the variables, called "rate factors", that health insurers proposed to use in their separately approved rate manuals for calculating their premiums quotes, rather than just reviewing the aggregated dollar value of proposed rates. Using rate factors as the basis for premium review has allowed Rhode Island to closely track cost driver trends that comprise premium rates. The three primary rate factors proposed by insurers were (1) projected administrative costs, (2) contribution to reserves (also considered surplus or profit), and (3) projected medical inflation. DBR assessed each factor's trend rate for consistency with the public interest and proper conduct of business.[2] DBR reviewed the sufficiency of proposed rates to monitor the continued solvency of each insurer as well as the adequacy of benefits consumers would receive in return for their premium payments.

In 2004, the Rhode Island legislature elevated health insurance regulation within DBR with legislation that established OHIC.[3] OHIC's creation was driven by two factors: (1) a perceived need for more comprehensive statutory authority to hold health insurers accountable for financial management, and (2) a recognition that health insurance is viewed by the public as

[1] Rhode Island General Law 42-62-13, 27-19-6 and 27-20-6 (Attachments A, B, and C)
[2] Rhode Island General Law 42-62-13, 27-19-6 and 27-20-6 (Attachments A, B, and C)
[3] Rhode Island General Law 42-14.5-1 (Attachment D)

qualitatively different than other types of insurance, consequently requiring a different type of oversight and regulation. When OHIC was established, regulatory standards governing health insurer conduct were substantially broadened in statute. In addition to actuarial soundness, financial solvency, and consumer protection, two additional criteria for the public interest were added for consideration. These were: (1) fair treatment of providers and (2) improving the affordability, quality and accessibility of medical care. We are not aware of any other state that currently directs regulators to consider broad health policy factors, such as fair treatment of providers and improvements in affordability, quality, and accessibility of medical care, when reviewing health plan conduct.[4] The statute gave little guidance to OHIC for assessing what constitutes actions for fair treatment of providers and improving affordability, quality, and accessibility of care; therefore, one of OHIC's most significant regulations, its "purposes regulation", further delineated the application of these new criteria in the rate factor review process.[5] In a key strategic decision in 2006, OHIC elected to apply these criteria in the annual rate factor review for small and large group business, substantially revising the process to require insurers to file rates annually, consistently across lines of business and across insurers, and transparently. The interests of the public in affordable health insurance and the interests of the insurer in sustainable rates are most clearly identified and in conflict in the rate factor review. These conflicting interests make rate review an ideal regulatory tool for leveraging affordability.

OHIC has made considerable strides in the past few years to define and apply standards of affordability to the rate factor review. In 2008 insurers were required to submit a plan for improving health insurance affordability. This disclosure alone produced limited results, as it did not engage providers, payers, or the public to improve system-wide affordability. Therefore, in

[4] Rhode Island General Laws 42-62-13, 27-19-6, 27-20-6 (Attachments A, B, and C)
[5] OHIC Regulation 2: Purposes Regulation. Pg. 2. (Attachment E)

2009 four key standards of affordability were developed by OHIC in collaboration with the Health Insurance Advisory Council (HIAC)[6] that could be measurably applied to insurers within the rate factor review. These standards require insurers to: (1) increase each insurer's proportion of medical expenses on primary care by one percentage point per year from 2010 – 2014; (2) support expanding the medical home initiative in Rhode Island, (3) fund the adoption and maintenance of electronic medical records as a percentage of market share, and (4) participate in an on-going dialogue about comprehensive state-wide payment reform.[7] The Commissioner considers compliance with these standards when issuing rulings for the annual rate factor review.

OHIC Rate Review Process - Components

OHIC's rate review process varies by product type. In the individual market there is a single carrier with five products. An annual rate hearing process is required by statute.[8] In the Medigap market, OHIC reviews rates by product as a carrier chooses to revise them. OHIC may approve the rates, suggest modifications for resubmission or initiate an administrative hearing. The processes for small and large group rate factor review will be described in greater detail because it effects more than half of Rhode Islanders and the process is unique to the state. OHIC can approve, reject or modify the inflation factors that insurers use to calculate the rates paid by consumers. Once these rate components are determined, insurers use rating formulas to calculate an employer-specific year long, fixed rate based on that employer's benefit plan and demographic mix. Past claims experience is also considered in the large group market. For small group, rates are based on adjusted community rating, with allowed variation for age, gender, and

[6] The HIAC is a statutorily mandated advisory group to OHIC, comprised of businesses, providers and consumers.
[7] OHIC Issue Brief, May 19, 2009. Available at: http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/6_Issue%20Brief.pdf
[8] Rhode Island General Laws 27-19-6 and 27-20-6 (Attachments B, and C)

family composition within a 4:1 rating band.[9] There are no equivalent statutory or regulatory requirements for large group rating rules; however, OHIC separately reviews insurers' rating formulas to ensure they are fair and are consistently applied.

The rate factor review process for small and large group rates occurs in four steps over the course of 45-60 days. These steps include: (1) preliminary internal review, (2) public comment, (3) internal actuarial and substantive review, and (4) rate factors proposal to carriers. Rate factor review for the individual market does not go through this process; rather, all individual filings automatically go to hearing pursuant to statute, as described in "Step 4" below.

Preliminary Internal Review: Health insurance carriers file their proposed rate factors utilizing the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF). The carriers use a standard form (Attachment H) to report their projected annual rate of price and utilization increases for the following categories: hospital inpatient, hospital outpatient, pharmacy, primary care, and all other medical, as well as the projected portion of premium for administrative costs and reserves or profits. These trends are also reported as the resulting overall average increase in commercial health insurance premiums. The Executive Counsel and consulting actuary review the proposed trend factors for completeness. They may ask for any clarifications from the health plans at this stage.

Public Comment: OHIC posts all proposed rate factors for oral and written public comment.[10] Public comments are usually collected for four weeks.[11] The rate factors are also presented to HIAC for analysis and comment. A publicly accessible rate review process assists OHIC in holding insurers accountable for goals that may conflict, including financial solvency,

[9] Rhode Island General Law 27-50-5 and OHIC Regulation 11, shown in Attachments F and G.
[10] Rhode Island General Laws that govern public disclosure and access to rate filing information include per the Access to Public Record Act (RIGL 38-1-1- et seq.), 27-19-6, 27-20-6, 42-62-13, as shown in Attachments A, B, C, and I. AG opinion PR 09-01 (http://www.riag.state.ri.us/civilcriminal/show.php?id=568) also applies.
[11] A copy of the public comment solicitation can be found as Attachment J.

consumer protections, fair treatment of providers, and implementing policies that improve affordability, quality, and accessibility of the health care system. At OHIC's discretion, rate factors may also be publicly discussed through public meetings and/or formal hearings.

Internal Review: The Health Insurance Commissioner, Executive Counsel, and consulting actuary work together to assess the actuarial soundness of proposed rate factors and their relationship to each carrier's solvency. The Superintendent of Insurance and the Chief Financial Examiner at DBR participate in this internal review as needed. In addition to financial solvency, OHIC considers the general conduct of insurers when reviewing proposed rate factors. Components considered as part of general conduct are summarized in Figure 1. OHIC also considers insurers efforts to improve system affordability, using the metrics for affordability standards as summarized in Figure 2. All internal analysis is completed using Microsoft Excel.

Propose Approved, Modified, or Rejected Rate Factors to Carriers: Upon completion of the internal review, the Health Insurance Commissioner accepts, modifies, or rejects the rate factors requested by the health insurers. OHIC sends a decision letter to each plan and allows health insurers to respond. Insurers can either re-file their rates in accordance with the proposed modifications or OHIC will call a hearing on the original filing. All rates are filed prospectively. OHIC has the authority but lacks resources to perform a comprehensive retrospective analysis to reconcile prior year's proposed versus approved rates. Market conduct examinations are generally conducted only if there is evidence or suspicion that insurers are not appropriately applying their approved rate factors to calculate premiums.

If an insurer does not re-file their rates in accordance with OHIC's proposed modifications, a full hearing is conducted in compliance with the state Administrative Procedure Act. The insurer(s) and attorney general (the attorney general is statutorily charged with representing the

public at a rate hearing) testify before a hearing officer regarding the proposed filing. The hearing officer makes a recommendation to OHIC, and the Commissioner issues a final decision. When rate factors are filed for the individual market by BCBSRI, the rate review occurs directly through a hearing, without first going through initial review, a public comment period, and internal review. Due to the statutorily mandated process required for rate hearings, individual market rate hearings usually require two months to complete. All significant final rate review decisions are posted in plain language on the OHIC web site and communicated in press releases.

Figure 1. Considerations for Evaluating Insurers' General Conduct [12]

1. Efforts by health insurers to develop benefit design and payment policies that:
- a. Enhance the affordability of products
- b. Encourage more efficient use of existing resources.
- c. Promote appropriate and cost effective acquisition of health care technology and expansion of existing infrastructure.
- d. Advance development and use of high quality health care centers.
- e. Prioritize use of limited resources.

2. Efforts by health insurers to promote the dissemination of information, increase consumer access to health care information, and encourage public policy dialog about increasing health care costs and solutions.

3. Efforts by health insurers to promote collaboration among the state's health insurers to promote standardization of administrative practices and policy priorities.

4. Directing resources, including financial contributions, toward system-wide improvements in the state's health care system related to quality, access and efficiency, including providing support to local collaboratives, organizations and initiatives that promote these system-wide improvements.

5. Participating in the development and implementation of public policy issues related to health.

6. The interests of the state's health insurance consumers, including:
- a. efforts by the health insurer to ensure that consumers are able to read and understand the terms and scope of the health insurance coverage documents issued or provided by the health insurer and make fully informed choices about the health insurance coverage provided by the health insurer;
- b. the effectiveness of the health insurer's consumer appeal and complaint procedures;
- c. the efforts by the health insurer to ensure that consumers have ready access to claims information;
- d. efforts by the health insurer to increase the effectiveness of its communications with its insureds, including, but not limited to, communications related to the insureds' financial responsibilities;
- e. ensuring that the benefits in health insurance coverage documents issued or provided by a health insurer are consistent with state laws; ensuring that the benefits delivered by a health insurer are consistent with those guaranteed by the health insurance coverage documents issued or provided by the health insurer; and
- f. that the insurer takes steps to enhance the affordability of its products.

7. The interests of the state's health care providers, including:
- a. that the policies, procedures and practices employed by health insurers with respect to provider reimbursement, claims processing, dispute resolution, and contracting processes are understandable and transparent; and
- b. that the efforts undertaken to enhance communications with providers

[12] Source: OHIC Regulation Two (Attachment E)

Figure 2. Metrics for Evaluation of the Affordability Standards[13]

Standard 1: Primary Care Spending
- Primary care satisfaction (OHIC annual survey)
- Primary care supply: number of total primary care providers
- Primary care supply: primary care physicians as a percentage of Rhode Island physicians
- Incidence of hospitalizations for ambulatory care–sensitive conditions
- Incidence of emergency room visits for ambulatory care–sensitive conditions
- Overall Rhode Island medical trend, for fully insured, commercial business

Standard 2: Spread Adoption of the Chronic Care Model Medical Home
- Improved performance on quality measures for three chronic conditions—coronary artery disease, diabetes mellitus, and depression—
- Reduced emergency room visits, inpatient readmissions, and system costs.

Standard 3: Standard Incentives to Use Electronic Medical Records
- Rate of EMR adoption

Standard 4: Work Toward Comprehensive Payment Reform
- Development of metrics for this standard are in process

Consumer Protections and Transparency

OHIC has made rate review transparency a critical aspect of its oversight strategy. All significant rate filings are publicly disclosed and prominently posted on OHIC's website. The statutes governing the rate review process require that "any documents presented in support of a filing of proposed rates under this section shall be made available for public examination at any time and place that the director may deem reasonable".[14] In 2007, insurers were required for the first time to submit rate factors simultaneously for large and small group products for public review and consideration. OHIC posted sections of the filing and associated analysis on its website for public review and comment. In 2008, OHIC published rate factors for administrative costs, profits and surplus, and five medical service categories, as well as the price and inflation factors for each of the medical service categories. This unprecedented transparency promoted

[13] Source: OHIC Affordability Standards, Available at: http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/6_Issue%20Brief.pdf

[14] Rhode Island General Laws that govern public disclosure and access to rate filing information include per the Access to Public Record Act (RIGL 38-1-1- et seq.), 27-19-6, 27-20-6, 42-62-13, as shown in Attachments A, B, C, and J. AG opinion PR 09-01 (http://www.riag.state.ri.us/civilcriminal/show.php?id=568) also applies.

consumer awareness of insurance cost drivers.[15] At the conclusion of each review, the rate decision and any health plan responses are posted to OHIC's website with related press releases.

Once rate factor decisions are made public, purchasers and brokers may use this information in evaluating their own rate increases. An OHIC bulletin described a standard quote sheet for insurers to use for small businesses so consumers understand what causes premium changes.[16] Finally, OHIC investigates individual complaints from brokers and businesses regarding specific quotes as those concerns are presented to OHIC. No data are compiled on the frequency of these complaints, since efforts have been focused on the rate review process.

Current Level of Resources and Capacity for Reviewing Health Insurance Rates

OHIC is annually appropriated approximately $550,000 in the state's budget in General Revenue Funds. Additionally, OHIC receives 75% of a full-time equivalent (FTE) for work related to consumer protections such as processing complaints and reviewing policies and other filed forms and one or more FTEs for financial examination from the DBR. OHIC uses consulting staff as needed for rate review and special examinations as called by the Commissioner. OHIC received 249 rate filings in 2009, most of which were for Medicare Supplement plans or other non-major medical plans. OHIC reviews small and large group rate factors annually for each of the three major medical insurers in the state, as well as individual market rates for BCBSRI. Overall, approximately 25% of OHIC's budget is spent for rate review, most of which is dedicated to staff time and consulting fees. Actuarial expenses are billed directly to health insurers by statute.[17] The Health Insurance Commissioner, a cabinet level official, has executive authority over the rate factor review. Christopher Koller is currently

[15] See attachment K for the rate factor template for consumers.
[16] See full text of bulletin at http://www.ohic.ri.gov/documents/Insurers/AdoptedBulletins/11_2008-3%20Small%20Group%20Annual%20filing.pdf
[17] Actuarial fees are billed to insurers per Rhode Island General Law 42-14-10 (Attachment M).

Commissioner.[18] The Executive Counsel to OHIC, an attorney with both industry and regulatory experience, provides legal expertise to the rate factor review process. OHIC contracts with an independent, self-employed, out-of-state actuary for all technical analyses. Since OHIC's inception, they have used DeWeese Consulting, Inc for virtually all actuarial services. Billings for actuarial services totaled $126,000 in 2009.

Successes and Challenges

Rhode Island has established a comprehensive, transparent rate factor review process that has achieved savings for Rhode Islanders. For example, rate factor decisions made by OHIC in 2008 resulted in $15-20 million in annual savings to large employers.[19] In 2009, insurers voluntarily withdrew their requests for rate increases in the small and large group markets, which effectively froze premium rates for six months. In the individual market, OHIC granted no rate increase in 2009 and rate increases of 8.7% and 7% in 2008 and 2010. A chart summarizing proposed and approved rate factors for 2008 – 2010 can be found in Attachment L.

B. Proposed Rate Review Enhancements for Health Insurance

The process previously described situates the state as a national leader in premium review. While OHIC has made much progress in the thoroughness and public accessibility of rate reviews, these reviews could be more comprehensive and effective. Public engagement, formal standards for evaluating medical and administrative costs, and resources available for analytical review have all been limited. OHIC proposes to use funds from this grant to improve its comprehensive rate review by focusing on improved analytics and consumer engagement, as well as enhanced oversight of health insurer efforts to reduce underlying cost drivers. OHIC will

[18] See Attachment #5 for Koller's resume.
[19] OHIC Press Release, June 13, 2008. Available at: http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/1_2008%20large%20group%20rate%20modification%20press%20release.pdf

share its monitoring and results with Federal Officials as well as make the information easily publicly accessible. To meet the objectives laid out in the grant advisory, OHIC proposes to use these grant funds to enhance health insurance rate review in the state by: (1) expanding the scope of current review and approval activities, (2) enhancing staffing, and (3) improving consumer protection standards and communications.

Expanding the scope of current rate review and approval activities

OHIC plans to allocate more than 50% of available federal funds to expand the scope of Rhode Island's current rate review and approval activities. This expansion will be primarily in two areas: (1) monitoring efforts to improve health insurance premium affordability, and (2) conducting analyses that support and inform rate review decisions.

Ensuring the affordability and sustainability of health insurance premiums has been a priority for OHIC and an integral part of the rate review process, however, the resources necessary to make the process effective have not been available. Since OHIC implemented affordability standards in 2009, initial affordability analyses have been limited and privately funded. Ongoing efforts are not built into OHIC's budget. With federal funding, OHIC will enhance its current capacity to monitor and enforce the affordability standards by hiring an external affordability consultant. Monitoring insurers' compliance with the affordability standards will be the consultant's chief responsibility. This consultant will oversee the two affordability evaluations described below, as well as engage in ad hoc analyses of underlying cost drivers of the health care delivery system. Rate factor review and enforcement will be enhanced by this improved monitoring effort, providing more information on which the Commissioner can base his/her rate rulings.

OHIC will use federal funds to support two initial affordability evaluations. OHIC will

dedicate $100,000 to complete an evaluation of the effects of its affordability standards with assistance from the RI Department of Health (HEALTH). This evaluation will assess trends in avoidable emergency room utilization, preventable hospitalizations, and readmissions. OHIC and HEALTH will establish a baseline utilization trend using historical data and produce a quarterly report to ensure close monitoring of any utilization trends or changes in trend. HEALTH will use its existing inpatient utilization database and will draw on national standards for these measures. This evaluation will also set a baseline for future inter-agency evaluations of cost drivers. The second evaluation will compare hospital payments for inpatient and outpatient care to hospital costs. Payments and costs will be evaluated by payer type (commercial, Medicare, and Medicaid) to document any cross-subsidization among payers that may contribute to rising commercial health insurance costs. This work springs directly from the initial transparency efforts by OHIC, which documented budgeted inpatient price trends of nine percent or more across all payers. Preliminary analytical work by OHIC also has documented variations in commercial insurer hospital payments by hospital but was incomplete – omitting other payers and outpatient services. These findings are not unique to Rhode Island, but understanding the phenomenon requires deeper analysis. In OHIC's experience, rate review must be connected to comprehensive delivery system analysis and transformation efforts, such as these analyses, to ensure affordable health insurance. A subcontractor will conduct the evaluation of hospital payments and costs. The affordability consultant will oversee both the utilization and hospital payment evaluations.

In addition to enhanced affordability monitoring, OHIC will expand the scope of current rate review activities with more detailed data analyses that support and inform rate factor review decisions. OHIC will contract with an actuary to reconcile past insurer rate factor requests and decisions with actual financial performance and results. OHIC has identified this need as a result

of past rate reviews, but a detailed and significant historical analysis has been outside the scope of the limited funding available for individual rate reviews. OHIC will be able to understand the financial impact of past rate decisions and health plan budgeting with the results of this analysis, facilitating a more accurate review of future rate factor filings. The analytical template will likely be useful to other states, and OHIC looks forward to sharing its results.

Finally, OHIC will subcontract with an analyst to develop a plan to align Rhode Island's current rate factor review with anticipated federal guidance for implementing premium review and for any health insurance exchange operating in Rhode Island as required by the Affordable Care Act. This dedicated analyst will also conduct an all-purpose evaluation of cost drivers throughout the grant-funded period. Analyses will include enrollment trends, financial health, interstate comparisons, benchmarks, and systemic cost drivers. The ongoing cost driver evaluation paid for by these grant funds will generate information to enhance OHIC's current rate review standards to permit the Commissioner to make more informed rate factor rulings.

Enhancing the Rate Review Process through Staffing

OHIC will use a portion of the federal grant funding to enhance staffing dedicated to the rate factor review process. Currently, OHIC has three FTE employees: the Health Insurance Commissioner, Executive Counsel, and Office Coordinator who supports both the Commissioner and the Counsel. OHIC will hire a full time rate review manager for the duration of the grant period to manage the formal rate filing process. This rate review manager will be responsible for obtaining all filings and posting decisions through SERFF. The manager will assist the actuary and Executive Counsel to review nearly 300 filings received by OHIC each year. This manager will also coordinate all communication with insurers and stakeholders related to rate review.

OHIC currently contracts with one actuary for all technical work related to the rate review

process. To enhance rate review capacity, OHIC will contract with their current external actuary to develop a robust database of past rate factor review submissions. The database will be constructed such that the manager, without actuarial expertise, may easily add future rate factor filings to the database. The manager will oversee this database development project, the ongoing maintenance of rate filing data in the database and will develop mechanisms to post this information on OHIC's website, improving the frequency with which it is used by the public.

OHIC is committed to working with HHS to develop, maintain and improve the quality of rate trend information in Rhode Island to be submitted to HHS and this person will be responsible for that function. OHIC has successfully implemented the SERFF process developed by NAIC for rate and form filing, and will invest funds as well as the manager's time with NAIC to expand and enhance SERFF to comply with Federal requirements for all data reporting.

Improve consumer protection standards and communications in the rate review process

OHIC has been committed to transparency and public disclosure of the maximum amount of information available for rate review, as well as worked to educate the public on health insurance cost drivers and the strengths and limitations of health insurance rate review. In spite of these efforts, OHIC has experienced limited public engagement with rate factor filing information – with sparsely attended public meetings and limited public comment. OHIC has few community partners in this work. Numerous special interest consumer advocacy groups exist for many government services, yet few naturally forming advocacy groups for affordable health insurance rate factors. Therefore, OHIC will dedicate a portion of these funds to contract with a community organization that can promote purchaser and consumer engagement in the rate review process. The organization would be responsible for collecting public comment and generating additional analyses relative to consumer engagement. The organization would also be

charged with raising awareness and knowledge of both the rate factor review process and underlying cost drivers of health insurance premium increases with purchasers and the public. With effective community partners, OHIC can meet several measurable goals – greater attendance at public meetings regarding rate factors, more and more informed communications regarding rate factors from the public and a more robust process for the work of the HIAC.

OHIC will contract with a consultant to communicate the results of evaluations conducted through this grant to health plans, hospitals, providers, regulators, and other interested stakeholders. OHIC will also hire a web consultant to increase traffic to OHIC's website. The designer will be responsible for recommending and implementing mechanisms for ensuring that rate filing data is readily accessible to consumers.

C. Reporting to the Secretary on Rate Increase Patterns

The OHIC attests that it will comply with the reporting requirements outlined in statute and in the grant solicitation. The rate review manager hired to manage the rate factor review process will collect and provide data to the Secretary on the timeline requested by HHS. OHIC will transmit the data using the uniform reporting template to be provided by HHS to grant awardees. OHIC will also provide trend data as requested from 2008 through 2011.

Summary: The combined enhancements to the scope of rate review and approval activities, staffing capacity, and consumer protection standards and communication in Rhode Island will greatly improve OHIC's already robust and transparent rate factor review process while aligning with any new federal premium review requirements. This proposal builds on OHIC's nation-leading work in premium rate review, meets HHS funding objectives for the Premium Review Grant, improves the effectiveness of the rate review process for Rhode Island's citizens and will provide valuable lessons for other states engaged in this important work.